

## Authorization for Release of Information

Name of Patient _____ Date of Birth _____	
Dr's Caldwell, Bills & Petrilli is authorized to release protected health information about the above named patient in the following manner and to identified persons.	
<b>Entity to Receive Information.</b> Check each person/entity that you approve to receive information.	<b>Description of information to be released.</b> Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name & phone number) _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication – Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment Reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number* _____ *For text communication to occur, please accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For <b>email and/or text communication</b> I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other

<p><b>Patient Rights:</b></p> <ul style="list-style-type: none"> <li>• I have the right to revoke this authorization at any time.</li> <li>• I may inspect or copy the protected health information to be disclosed as described in this document.</li> <li>• Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.</li> <li>• Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.</li> <li>• I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.</li> </ul>
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\_\_\_\_\_  
Date \_\_\_\_\_

Signature of Patient or Personal Representative

\*Description of Personal Representative's Authority (attach necessary documentation)

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